Remarks by Videoconference of U.S. Senator Tom Coburn, M.D. (R-OK)
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A Shameful Decade for Malaria Control

We all know that global malaria control has gotten off-track and the consequences have been devastating. While donors were funding more bed-net research and advice-giving programs, millions of children died in their mothers' arms. Not only did Roll Back Malaria fail to meet its target of cutting malaria rates in half, the partnership presided over an ***increase*** in the malaria mortality rates. At the same time, the foreign aid industrial complex of western consultants and for-profit contracting firms headquartered in Washington and Geneva grew exponentially along with donor malaria budgets.

Exhortation to Reform

And yet, the interventions that were scaled up so successfully decades ago to conquer malaria in richer countries were excluded during the past decade – the combination of spraying affected areas with DDT coupled with the large-scale use of effective drugs. Donors instead preferred to fund interventions that had never been proven to show nationwide impact anywhere, and that's if they were evaluated at all – handing out massive multi-year advice-giving contracts, supporting drug programs using older drugs in the absence of appropriate resistance data, and social marketing of bed-nets that failed to achieve the coverage levels that bring overall infection rates down. While these programs were well-intentioned and occasionally tested well under controlled conditions in small populations, they were never subjected to the rigor of large-scale trials against the proven DDT + drug strategy of the mid-20th century.

The tiny kids and pregnant moms losing their lives every day can't wait around for us to bicker about whether the newer interventions have *really* failed or just haven't been *funded* enough. If saving their lives means dispensing with the more politically correct approaches to malaria control, then so be it. The years of failure have eviscerated any defense of a continued ideological bias against brand-name pharmaceuticals or the junk-science stigma attached to DDT. Fortunately, in the past few years, there has been a return to sanity. I want to commend those who led the way, including the much-reviled *Lancet* authors' group, Brian Sharp and his team in South Africa, President Museveni of Uganda, Africa Fighting Malaria, U.S. Senator Sam Brownback and others. I *especially* want to commend those organizations who have faced withering criticism, managed to overcome institutional defensiveness and choose the path of reform.

It's very easy for politicians and academics to throw stones. But the real heroes are the donors and organizations actually running programs in the field who have been trying to overcome the many obstacles to reform. These include the Global Fund and USAID. I can see that WHO has started down the right path as well, and I thank Dr. Kochi for his leadership in this area. I am hopeful that the World Bank will use recent criticism as an ***opportunity*** to reform rather than defensively ***dig in***.

Policy Priorities

So far I've focused on the ***process*** of reform. I'd like to talk a little bit about the ***policy***, and what policy-makers in Washington are looking for from malaria control programs - if they hope to continue receiving U.S. funding:

1) First and foremost, a commitment to **transparency**. Transparency costs money. It takes time and work to put everything you're doing and funding on a web site. But it is simply non-negotiable. We have a long way to go on this, especially with respect to the UN, including WHO, and the World Bank. The benefits are clear:

- Other donors know exactly what you're doing and where, so they can better coordinate their own activities to maximize program coverage.
- Critics can't falsely accuse you of anything because everything you're doing or not doing is public.
- Your staff don't have to spend all their time responding to sometimes-hostile document requests from legislators, donors, activist groups, and other stakeholders.
- But most of all, lives are saved because poorly performing programs are exposed much more quickly – meaning they can be fixed right away.

2) The second policy priority is that the underutilized and wildly successful intervention of **indoor residual spraying (IRS)**, especially with DDT, needs to be immediately de-stigmatized and aggressively funded. WHO has long been part of the problem and I am very encouraged by the sea change these draft IRS guidelines represent. Dr. Kochi and his team are to be commended. But the guidelines are only a beginning. We will be watching closely to see that WHO turns these words into action and uses every means of influence it has to pressure all programs to use IRS as the rule rather than the exception.

Indoor spraying is safe. Malarial mosquitoes are not. Does it require infrastructure and public health capacity? You bet. But so does a high-coverage bed-net program, or an HIV antiretroviral program. That can't stop us. Does it require working with communities to increase public acceptance? You bet. But so do HIV prevention programs and girls' education programs and a host of public health programs we have long embraced.

(2)(a) Now, let me say a few words about **DDT**.

Sure, DDT is bulky to carry around. DDT can harm wildlife if it gets into the environment. DDT leaves white stains on walls. We've all heard these complaints over and over again. What hasn't gotten as much airtime, though, is that DDT is simply the cheapest, most effective vector control substance in the world.

- Repellency: Just a whiff of it repels the vast majority of mosquitoes from even entering a house sprayed with DDT – no other insecticide comes close in repellency.
- Irritancy: But the few brave bugs who make it in the house face DDT's irritancy function. Most of them will flee the house without stopping to bite or sit on a wall.
- Toxicity: Then, the hardiest bugs that bite and then rest on a wall die right away. At field concentrations, DDT's killer toxicity is about the same as other insecticides. But other chemicals are much less effective because they don't provide long-term protection. DDT does. DDT has powerful repellency that other chemicals don't have.

- Did I mention that it's cheaper - in some cases, ***much cheaper*** **-** than other chemicals?
- Safety: It is safe when used ***properly*** inside homes – that is, it does not escape into the environment. When bed-nets are improperly used as fishing nets or window screens, they can dump insecticides into the environment too. Any vector control intervention must be carried out ***properly***. When done so, DDT is safe, and we should be aggressively using the public health exemption to the Stockholm Convention DDT ban.

Which brings me to the next policy priority:

3) I want to call on the European Union to immediately **end any economic intimidation** of poor countries who want to spray DDT to save their childrens' lives. The over-the-top agricultural trade standards, the denials of this intimidation ***on*** the record, while opposite messages are being delivered ***off*** the record – all of it has to stop. Indoor residual spraying has never been shown to harm the environment or poison food, so all claims of public health protection using these trade standards are nonsense. If the EU ***is***, as it ***claims***, really supportive of any country's use of DDT to control malaria, then let's just clear up the confusion right now. I urge them to issue a statement of enthusiastic support for the use of DDT by any country threatened by malaria, and to pledge not to use hide economic arm-twisting under the guise of public health. Lives are at stake, and sound malaria policy should not be hijacked by this underhanded form of trade protectionism.

4) Fourth, we need to support **effective medications** and immediately end support for ineffective medications. I understand that we may not have ***perfect*** resistance data everywhere. But here's the question: if you were in doubt about the strain or resistance of the parasite that had infected your two-year-old, what drug would you want her to take? Maybe she has *p. vivax*. Or maybe her *p. falciparum* [fal-SIP-uh-rum] is susceptible to chloroquine. But if it's ***your*** child convulsing with fever in your arms, would you risk it? When in doubt, we need to err on the side of caution. Sure, we should improve our resistance surveillance efforts, but in the meantime, getting a drug that works right away is literally a matter of life and death with this disease. We can't afford to waste the couple of days it takes to figure out we gambled wrong with an obsolete drug. Donors need to aggressively purchase ACT (artemisinin-based combination therapy). As you know, it takes a while to grow, so we need to get the orders in right away. If one of my grandkids were infected with malaria, I would settle for nothing less than ACT. We must treat other people's children the same way we would treat our own.

5) In addition, we need to **scale up interventions** to a level that will actually put a dent in the malaria burden. Increasing malaria mortality rates while we fund ***tiny*** programs of marginal impact all over the world simply won't work - we need interventions on a regional and national scale. The money is finally there, thanks to the efforts led primarily by the Global Fund, President Bush's Malaria Initiative, the Gates Foundation and others. But we've got to be smart and plan together which countries we each work in . We should start with the most strategic spots: high-burden countries whose governments are ready to ramp up.

6) Finally, our programs need to be based on **life-saving commodities** – purchasing and distributing them, and measuring their impact. The vast majority of our money needs to be spent on items that actually *touch sick people or people at immediate risk of becoming sick* – drugs,

spraying, nets, and diagnostics. Let's sign the contracts with the consultants ***after*** we've committed to large-scale commodity purchase so the consulting industry can help us get those commodities out to sick people rather than compete for funds with them.

Conclusion

I don't doubt for a minute that you are all passionately committed to ending the devastation caused by malaria. You have dedicated your lives and careers to this cause and I applaud you for it. With that, I'll yield the floor, as we say here, back to Dr. Kochi. Thanks so much for letting me participate today.